47. Physician's Assistant. A person who is licensed by the Idaho Board of Medicine and who meets at least one of the following provisions: (11-10-81)

a. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or (11-10-81)

b. Has satisfactorily completed a program for preparing physician's assistants that: (11-10-81)

i. Was at least one (1) academic year in length; and (11-10-81)

ii. Consisted of supervised clinical practice and at least four (4) months, in the aggregate, of classroom instruction directed toward preparing students to deliver health care; and (11-10-81)

iii. Was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation. (11-10-81)

48. Plan of Care. A written description of medical, remedial and/or rehabilitative services to be provided to a recipient, developed by or under the direction and written approval of a physician. Medications, services and treatments are identified specifically as to amount, type and duration of service. (10-6-88)

49. Premium or Subscription Charge. The per capita amount paid by the Department for each eligible MA recipient enrolled under a contract for the provisions of medical and rehabilitative care and services whether or not such a recipient receives care and services during the contract period. (11-10-81)

50. Property. The homestead and all personal and real property in which the recipient has a legal interest. (11-10-81)

51. Prosthetic Device. Replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts profession within the scope of his practice as defined by state law to: (10-1-91)

a. Artificially replace a missing portion of the body; or (10-1-91)

b. Prevent or correct physical deformities or malfunctions; or (10-1-91)

c. Support a weak or deformed portion of the body. (10-1-91)

52. Provider. Any individual, organization or business entity furnishing medical goods or services in compliance with chapter and who has applied for and received a provider number, pursuant to Section 020., and who has entered into a written provider agreement, pursuant to Section 040. (12-31-91)

53. Provider Agreement. An agreement between the provider and the Department, entered into pursuant to Section 040. (12-31-91)

54. Provider Reimbursement Manual. Idaho Department of Health and Welfare Rules, Title 03, Chapter 10, "Rules Governing Provider Reimbursement in Idaho." (11-10-81)

55. Psychology Assistant. An individual who practices psychology under the supervision of a licensed psychologist when required under Chapter 23, Title 54, Idaho Code, and Section H of the "Rules of the Idaho State Board of Psychologist Examiners." (10-6-88)

56. Recipient. An individual who is receiving Medical Assistance. (11-10-81)

57. Recreational Therapy (Services). Those activities or services that are generally perceived as recreation such as, but not limited to, fishing, hunting, camping, attendance or participation in sporting events or practices, attendance at concerts, fairs or rodeos, skiing, sightseeing, boating, bowling, swimming, training for special olympics, and special day parties (birthday, Christmas, etc.). (10-6-88)

58. Regional Nurse Reviewer (RNR). A registered nurse who reviews and makes determinations on applications for entitlement to and continued participation in Title XIX long term care for the Department. (7-1-94)

59. Social Security Act. 42 USC 101 et seq., authorizing, in part, federal grants to the states for medical assistance to low-income persons meeting certain criteria. (11-10-81)

60. Specialized Family Home. Living situation where a maximum of two (2) waiver recipients who do not require a skilled nursing service live with a provider family of residential habilitation services. (1-1-95)T

61. Subluxation. A partial or incomplete dislocation of the spine. (11-10-81)

62. Supervision. Procedural guidance by a qualified person and initial direction and periodic inspection of the actual act, at the site of service delivery. (6-21-90)

63. Title XVIII. That program established by the 1965 Social Security Act authorizing funding for the Medicare Program for the aged, blind, and disabled. The term is interchangeable with "Medicare." (11-10-81)

64. Title XIX. That program established by the 1965 Social Security Act authorizing the Medical Assistance Program, commonly referred to as "Medicaid," which is jointly financed by the federal and state governments and administered by the states. The term is interchangeable with "Medicaid." (11-10-81)

65. Third Party. Includes a person, institution, corporation, public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability of a recipient of medical assistance. (11-10-81)

66. Transportation. The physical movement of a recipient to and from a medical appointment or service by the recipient, another person, taxi or common carrier. (10-6-88)

67. Utilization Control (UC). A program of prepayment screening and annual review by at least one (1) Regional Nurse Reviewer to determine the appropriateness of medical entitlement and the need for continued medical entitlement of applicants/recipients to Title XIX benefits in a NF. (7-1-94)

68. Utilization Control Team (UCT). A team of Regional Nurse Reviewers which conducts on-site reviews of the care and services in the NFs approved by the Department as providers of care for eligible medical assistance recipients. (7-1-94)

69. Vocational Services. Services or programs which are directly related to the preparation of individuals for paid or unpaid employment. The test of the vocational nature of the service is whether the services are provided with the expectation that the recipient would be able to participate in a sheltered workshop or in the general work force within one (1) year. (10-6-88)

70. Waiver Facility. A licensed ICF/MR facility of eight (8) beds or less that has converted to a group home to provide residential habilitation services to developmentally disabled waiver recipients. Room and board is not included in the reimbursement rate. (1-1-95)T

004. ABBREVIATIONS. For these rules, the following abbreviations will be as defined: (7-1-93)

01. AABD. Aid to the Aged, Blind, and Disabled. (11-10-81)

02. AAP. American Academy of Pediatrics. (8-1-92)

03. APA. The Administrative Procedures Act, Title 67, Chapter 52, Idaho Code. (11-10-81)

04. A/R. Applicant/Recipient. (11-10-81)

05. ASC. Ambulatory Surgical Center. (9-30-84)

06. ASHA. American Speech and Hearing Association. (11-10-81)

07. B.I.A. Bureau of Indian Affairs. (11-10-81)

08. CFR. Code of Federal Regulations. (11-10-81)

09. CRVS. California Relative Value Studies. (11-10-81)

10. DME. Durable Medical Equipment. (11-1-86)

11. D.O. Doctor of Osteopathy. (11-10-81)

12. DVR. Department of Vocational Rehabilitation. (11-10-81)

13. EAC. Estimated Acquisition Cost. (11-10-81)

14. EOMB. Explanation of Medical Benefits. (11-10-81)

15. EPSDT. Early and Periodic Screening, Diagnosis, and Treatment. (11-10-81)

16. ICF/MD. Intermediate Care Facility/Medical Disease. (11-10-81)

17. ICF/MR. Intermediate Care Facility/Mentally Retarded. (11-10-81)

18. IOC. Inspection of Care. (1-1-83)

19. IOCT. Inspection of Care Team. (1-1-83)

20. IRS. Internal Revenue Service. (11-10-81)

21. MA. Medical Assistance. (11-10-81)

22. MAC. Maximum Allowable Cost. (11-10-81)

23. M.D. Medical Doctor (11-10-81)

24. MMIS. Medicaid Management Information System. (11-10-81)

25. NF. Licensed Nursing Facility. (8-1-92)

26. PASARR. Preadmission Screening and Annual Resident Review. (7-1-94)

27. PSRO. Professional Services Review Organization. (11-10-81)

28. QMHP. Qualified Mental Health Professional. (7-1-94)

29. QMRP. Qualified Mental Retardation Professional. (4-30-92)

30. REOMB. Recipient's Explanation of Medicaid Benefits. (11-10-81)

31. R.N. Registered Nurse. (4-30-92)

32. RSDI. Retirement, Survivors, and Disability Insurance. (11-10-81)

33. SMA. State Maximum Allowance. (11-10-81)

34. SSA. Social Security Administration. (11-10-81)

35. SSI. Supplemental Security Income. (11-10-81)

36. S/UR. Surveillance and Utilization Review. (11-10-81)

37. TPL. Third Party Liability. (11-10-81)

38. UC. Utilization Control (7-1-94)

39. UCT. Utilization Control Team. (7-1-94)

40. UR. Utilization Review. (11-10-81)

005. SINGLE STATE AGENCY AND STATEWIDE OPERATION. The Idaho Department of Health and Welfare has the authority to administer the Title XIX Medical Assistance Program on a statewide basis in accordance with standards mandatory throughout the State and set forth herein. (11-10-81)

006. -- 009. (RESERVED).

010. PUBLIC ACCESS TO PROGRAM INFORMATION (7-1-93)

01. Location of Rules Governing Medical Assistance. A current copy of the rules governing medical assistance, as well as other MA program information affecting the public, is to be maintained by the Department in the Central Office and in each field office. (11-10-81)

02. Availability of Materials. Copies of the rules governing medical assistance or other MA program information affecting the public will be furnished to any individual or organization who, in accordance with Idaho Department of Health and Welfare Rules and Regulations, Title 5, Chapter 1, "Rules Governing the Protection and Disclosure of Department Records (Confidentiality)": (11-10-81)

a. Formally requests specific information; or (11-10-81)

b. Formally requests to be placed on a mailing list to receive amendments to MA program policy from the Department's Administrative Procedure Section. (11-10-81)

03. Cost of Materials. A fee, to cover actual reproduction costs, will be assessed for all requests for copies of information. (11-10-81)

011. -- 013. (RESERVED).

014. COORDINATED CARE. (6-1-94)

01. Establishment. The Department may, in its discretion, and in consultation with local communities, organize and develop area specific plans as part of a coordinated care program. (6-1-94)

a. Flexibility. Since community needs and resources differ from area to area, the Department will maintain the flexibility to design plans which are consistent with local needs and resources. (6-1-94)

b. Waiver Programs. Plans may be either voluntary, or mandatory pursuant to waiver(s) granted by the Health Care Financing Administration. Some plans may start as voluntary and subsequently become mandatory. (6-1-94)

c. Models. It is anticipated that coordinated care will be accomplished principally through primary care case management. However, capitated plans may also be utilized. (6-1-94)

d. Purpose. The purposes of coordinated care are to: (6-1-94)

i. Ensure needed access to health care; (6-1-94)

ii. Provide health education; (6-1-94)

iii. Promote continuity of care; (6-1-94)

iv. Strengthen the patient/physician relationship; and, (6-1-94)

v. Achieve cost efficiencies. (6-1-94)

02. Definitions. For purposes of this section, unless the context clearly requires otherwise, the following words and terms shall have the following meanings: (6-1-94)

a. "Clinic" means two or more qualified medical professionals who provide services jointly through an organization for which an individual is given authority to act on its behalf. It also includes Federally Qualified Health Centers (FQHCs) and Certified Rural Health Clinics. (6-1-94)

b. "Coordinated care" is the provision of health care services through a single point of entry for the purposes of managing patient care with an emphasis on preventative and primary care and reducing inappropriate utilization of services and resulting costs. This is sometimes referred to as "managed care." (6-1-94)

c. "Covered services" means those medical services and supplies for which reimbursement is available under the state plan. (6-1-94)

d. "Emergency care" means the immediate services required for the treatment of a condition for which a delay in treatment could result in death or permanent impairment of health. (6-1-94)

e. "Grievance" means the formal process by which problems and complaints related to coordinated care are addressed and resolved. Grievance decisions may be appealed as provided herein. (6-1-94)

f. "Non-exempt services" means those covered services which require a referral from the primary care provider. It includes all services except those that are specifically exempted. (6-1-94)

g. "Outside services" means non-exempt covered services provided by other than the primary care provider. (6-1-94)

h. "Patient/recipient" means any patient who is eligible for medical assistance and for which a provider seeks reimbursement from the Department. (6-1-94)

i. "Plan" means the area specific provisions, requirements and procedures related to the coordinated care program. (6-1-94)

j. "Primary care case management" means the process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient. (6-1-94)

k. "Qualified medical professional" means a duly licensed physician in the following specialties: Pediatrics, Internal Medicine, Family Practice, General Practice, General Surgery, Obstetrics/Gynecology, or a physician in any other specialty who chooses to assume the function of primary care case management. It also includes nurse practitioners, and physician assistants. Licenses must be held in the state(s) where services are being rendered. (6-1-94)

l. "Referral" means the process by which patient/recipients gain access to non-exempt covered services not provided by the primary care provider. It is the authorization for non-exempt outside services. (6-1-94)

m. "Waiver" means the authorization obtained from the Health Care Financing Administration to impose various mandatory requirements related to coordinated care as provided in sections 1915(b) and 1115 of the Social Security Act. (6-1-94)

03. Primary Care Case Management. Under this model of coordinated care, each patient/recipient obtains medical services through a single primary care provider. This provider either provides the needed service, or arranges for non-exempt services by referral. This management function neither reduces nor expands the scope of covered services. (6-1-94)

a. Referrals. The primary care provider is responsible for making all reasonable efforts to monitor and manage the patient/recipient's care, providing primary care services, and making referrals for outside services when medically necessary. All outside services not specifically exempted require a referral. Outside services provided without a referral will not be paid. All referrals shall be documented in recipient's patient record. (6-1-94)

b. Exempted Services. All services are subject to primary care case management unless specifically exempted. The following services are exempt: family planning services, emergency care, dental care, Podiatry, Audiology, Optical/Ophthalmology/Optometrist services, chiropractic, pharmacy, nursing home, ICF/MR services, and immunizations. (6-1-94)

04. Participation. (6-1-94)

a. Provider Participation. (6-1-94)

i. Qualifications. Primary care case management services may be provided by qualified medical professionals, licensed to practice in the state where services are being rendered. (6-1-94)

ii. Conditions and Restrictions. (6-1-94)

(1) Quality of Services. Provider shall maintain and provide services in accordance with community standards of care. Provider shall exercise his/her best efforts to effectively control utilization of services. Providers must provide 24 hour coverage by telephone to assure patient/recipient access to services. (6-1-94)

(2) Provider Agreements. Providers participating in primary care case management must sign an agreement. Clinics may sign an agreement on behalf of their qualified medical professionals. (6-1-94)

(3) Patient Limits. Providers may limit the number of patient/recipients they wish to manage. Subject to this limit, the provider must accept all patient/recipients who either elect or are assigned to provider, unless disenrolled in accordance with the next paragraph. Providers may change their limit effective the first day of any month by written request thirty (30) days prior to the effective date of change. (6-1-94)

(4) Disenrollment. Instances may arise where the provider/patient relationship breaks down due to failure of the patient to follow the plan of care or for other reasons. Accordingly, a provider may choose to withdraw as patient/recipient's primary care provider effective the first day of any month by written notice to the patient/recipient and the Department thirty (30) days prior to the date of withdrawal. This advance notice requirement may be waived by the Department. (6-1-94)

(5) Record Retention. Providers must retain patient and financial records and provide the Department or its agent access to those records for a minimum of five (5) years from the date of service. Upon the reassignment of a patient/recipient to another provider, the provider must transfer (if a request is made) a copy of the patient's medical record to the new provider. Provider must also disclose information required by section 040.01 of this chapter, when applicable. (6-1-94)

(6) Termination or Amendment of Provider Agreements. The Department may terminate a provider's agreement as provided in section 040.03 of this chapter. An agreement may be amended for the same reasons. (6-1-94)

iii. Payment. Providers will be paid a case management fee for primary care case management services in an amount determined by the Department. The fee will be based on the number of patient/recipients enrolled under the provider on the first day of each month. For providers reimbursed based on costs, such as Federally Qualified Health Centers and Rural Health Clinics, the case management fee is considered one hundred percent (100%) of the reasonable costs of an ambulatory service. (6-1-94)

b. Recipient Participation. (6-1-94)

i. Enrollment. (6-1-94)

(1) Voluntary Programs. In voluntary plans, the patient/recipient will be given an opportunity to choose a primary care provider. If the patient/recipient is unable to choose a provider but wishes to participate in the plan, a provider will be assigned by the Department. If a voluntary plan subsequently becomes mandatory, provider selection/assignment will remain unchanged where possible. (6-1-94)

(2) Mandatory Programs. In mandatory plans, a provider will be assigned if the patient/recipient fails to choose a participating provider after given the opportunity to do so. Members of the same family do not have to choose the same provider. All patient/recipients in the plan area are required to participate in the plan unless individually granted an exception. Exceptions from participation in mandatory plans are available for patient/recipients who: (6-1-94)

(A) Have to travel more than thirty (30) miles, or thirty (30) minutes to obtain primary care services; (6-1-94)

(B) Have an eligibility period that is less than 3 months; (6-1-94)

(C) Live in an area excluded from the waiver; (6-1-94)

(D) Have an eligibility period that is only retroactive; or (6-1-94)

(E) Are eligible only as medically needy. (6-1-94)

ii. Changing Providers. If a patient/recipient is dissatisfied with his/her provider, he/she may change providers effective the first day of any month by requesting to do so in writing no later than fifteen (15) days in advance. This advance notice requirement may be waived by the Department. (6-1-94)

iii. Changing Service Areas. Patient/recipients enrolled in a plan cannot obtain non-exempt services without a referral from their primary care provider. Patient/recipients who move from the area where they are enrolled must disenroll in the same manner as provided in the preceding paragraph for changing providers, and may obtain a referral from their primary care provider pending the transfer. Such referrals are valid not to exceed thirty (30) days. (6-1-94)

05. Problem Resolution. (6-1-94)

a. Intent. To help assure the success of coordinated care, the Department intends to provide a mechanism for timely and personal attention to problems and complaints related to the program. (6-1-94)

b. Local Program Representative. To facilitate problem resolution, each area will have a designated representative at the local or regional level who will receive and attempt to resolve all complaints and problems related to the plan and function as a liaison between patient/recipients and providers. It is anticipated that most problems and complaints will be resolved informally at this level. (6-1-94)

c. Registering a Complaint. Both patient/recipients and providers may register a complaint or notify the Department of a problem related to the coordinated care plan either by writing or telephoning the local program representative. All problems and complaints received will be logged. The health representative will attempt to resolve conflicts and disputes whenever possible and refer the complainant to alternative forums where appropriate. (6-1-94)

d. Grievance. If a patient/recipient or provider is not satisfied with the resolution of a problem or complaint addressed by the program representative, he/she/ may file a formal grievance in writing to the representative. The representative may, where appropriate, refer the matter to a review committee designated by the Department to address issues such as quality of care or medical necessity. However, such decisions are not binding on the Department. The Department will respond in writing to grievances within thirty (30) days of receipt. (6-1-94)

e. Appeal. Decisions in response to grievances may be appealed. Appeals by patient/recipients are considered as fair hearings and appeals by providers as contested cases under the Rules Governing Contested Case Proceedings and Declaratory Rulings, 16 IDAPA, Title 05, Chapter 03, and must be filed in accordance with the provisions of that chapter. (6-1-94)

015. CHOICE OF PROVIDERS. (7-1-93)

01. Service Selection. Each recipient may obtain any services available from any participating institution, agency, pharmacy, or practitioner of his choice, unless enrolled in a coordinated care plan. This, however, does not prohibit the Department from establishing the fees which will be paid to providers for furnishing medical and remedial care available under the MA Program, or from setting standards relating to the qualifications of providers of such care. (6-1-94)

02. Lock-In Option. (7-1-93)

a. The Department may implement a total or partial lock-in program for any recipient found to be misusing the MA Program according to provisions in Subsection 190.05.; but (12-31-91)

b. In situations where the recipient has been restricted to a recipient lock-in program, that recipient may choose the physician and pharmacy of his choice. The providers chosen by the lock-in recipient will be identified on the recipient's identification card each month. (11-10-81)

03. Out-of-State Care Provided Outside The State of Idaho. All out-of-state medical care requires preauthorization by the Department or the Department's designated Peer Review Organization (PRO), with the exception of bordering counties and emergency or urgent medical care. (2-15-93)

a. MA recipients may receive medical care and services from providers located in counties bordering Idaho without preauthorization by the Department. However PRO review may be required pursuant to Subsections 070.04. and 080.02. Approval by the Bureau of Medicaid Policy and Reimbursement, or its successor, is required for all long-term care outside the state of Idaho pursuant to Subsection 015.03.e. (2-15-93)

b. Emergency/urgent out-of-state care. (2-15-93)

i. Emergency/urgent inpatient hospital care must be reviewed using the same procedures and guidelines as in-state emergency hospital admissions by the PRO. Transfers from an Idaho Hospital to an out-of-state nonadjacent county hospital must be reviewed using the same procedures and guidelines as in-state transfers by the PRO. (2-15-93)

ii. Emergency/urgent out-of-state outpatient hospital, clinic and/or physician services do not require review by the Department or the Department's approved PRO. The provider must supply sufficient information to support a finding that the care provided was for an emergency/urgent situation. (2-15-93)

c. The Regional Medicaid Unit (RMU) will preauthorize all nonemergency care provided out-of-state for outpatient hospital services, rural health clinics, federally qualified health centers, physician services and physician extender services, dental services, podiatrists services, optometric services, chiropractor services, home health services, physical therapy services, occupational therapy services, speech and audiology services, private duty nursing, clinic services, rehabilitative services, services, and personal care services. (2-15-93)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipients residence or if no preauthorization was obtained prior to the date of the service as required. (2-15-93)

iii. The only exceptions to the preauthorization requirement are: (2-15-93)

(a) When eligibility for Medicaid is determined after the service was provided. The service still must be determined to be not available closer to the recipient's residence. (2-15-93)

(b) Out-of-state nonadjacent county lab and x-ray services when the recipient does not have to travel outside the state for the services to be provided. (2-15-93)

(c) Mail order pharmacies will not require preauthorization when the recipient is not required to travel outside the state to receive the service. (2-15-93)

(d) Services for which Medicare is the primary payer of service. (2-15-93)

i. A request for out-of-state preauthorization may be initiated by the recipient, the recipient's physician(s), and/or the treating facility. The preauthorization must be obtained prior to the scheduled date of the nonemergency service. Failure to request a timely authorization will result in denial of Medicaid payment for the out-of-state care and any associated transportation costs. (2-15-93)

ii. There will be no Medicaid payment if the service is determined to be available closer to the recipients residence or if no preauthorization was obtained prior to the date of the service as required. (2-15-93)

iii. The treating physician and the admitting facility is responsible for assuring that the Department's designated PRO has preauthorized the out-of-state nonemergency service for inpatient care. (2-15-93)

iv. No payment for services not preauthorized by the Department's designated PRO may be obtained from the recipient, absent the Medicaid recipient's informed decision to incur the cost of services. (2-15-93)

v. The only exceptions to the preauthorization requirement are: (2-15-93)

(a) When eligibility for Medicaid is determined after the service was provided. The service still must be determined not to be available closer to the recipient's residence. (2-15-93)

(b) Services for which Medicare is the primary payer of service. (2-15-93)

vi. The PRO review will be governed by provisions of the PRO provider manual as amended. (2-15-93)

e. Long-term care outside the State may be approved by the Department on an individual basis in temporary or emergency situations. Nursing home care will be limited to the period of time required to safely transport the recipient to an Idaho facility. Out-of-state care will not be approved on a permanent basis. (11-10-81)

016. -- 019. (RESERVED).

020. PROVIDER APPLICATION PROCESS. (7-1-93)

01. In-state Provider Application. In-state providers may apply for provider numbers with the Bureau. Those in-state providers who have previously been assigned a Medicare number may retain that same number. The Bureau will confirm the status for all applicants with the appropriate licensing board and assign a Medicaid provider number (s). (3-22-93)

02. Out-of-State Provider Application. Out-of-state providers who wish to participate in the Medical Assistance Program must complete a provider application and be assigned a provider number by the Bureau. The Bureau will contact a representative of Medicaid or a licensing agency in the state in which the provider practices to confirm the provider applicant's professional status and license number. (11-10-81)

03. Denial of Provider Application. The Bureau must not accept the application of a provider who is suspended from Medicare or Medicaid in another state. (11-10-81)